AGED AND DISABLED WAIVER
REQUEST FOR SERVICE LEVEL CHANGE

MEMBER INFORMATION:

Name: _____Birth date: ___/_____/_____ Medicaid # _____

Street Address: _____City: _____State: _____ Zip: _____

County: _____

Legal Representative, if applicable: _____Phone: _____

Member/ Legal Representative Signature:_____

Current PAS Date: _____

AGENCY INFORMATION:

Agency Name: _____

Street Address: _____City: _____State: _____ Zip: _____

Phone: _____Fax: _____

_____

RN Signature Date

REQUIRED DATA MUST BE SUBMITTED WITH THIS FORM:
☐ A completed copy of this cover sheet with **original signatures**
☐ A narrative explaining the need for Service Level change.
☐ A physician statement explaining the need for Service Level change.
☐ Current ADW PAS.
☐ Current Plan of Care or Participant Directed Service Plan
□ Proposed Service Plan Addendum
☐ Any additional documentation that substantiates the request.

Send all required documents to: Innovative Resource Group, 100 Capitol Street, Suite 600, Charleston, WV 25301. Fax: 866-521-6882